Medical Assistance Provider Agreement

Read Instructions Before Completing • Signature Required on Page 2

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

1. Check Type of Enrollment Request:

a. ❑ New Provider Number c. ❑ New FTIN Number

b. ❑ New Member to Group d. ❑ Update Expired Provider No.

e. **Current 11-Digit Provider Number**

See Completion Instructions for importance of data in fields 2 and 3.

2. Social Security Number (Use only if not enrolling under FTIN)	3. Federal Tax I.D. Number
Social Security Number Issued to:	Federal I.D. # Issued to: Date Issued:

4. Check if any provider listed on the agreement has been suspended or terminated from any government medical program.

❑ Yes ❑ No If yes: Name: _____ Date: _____

5. Provider Name and Address	6. Pay to Name and Address (if different from 5)
Full Name and Title	Name
Street Address (Physical Location - P.O. Box alone not accepted)	Mailing Address
City State Zip	City State Zip
Telephone Number ( )	Telephone Number ( )

7. Type of Provider (See instructions for list)	7a. Primary Specialty	7b. NCPDP #
8. License Number	9. Medicare Number	10. NPI # Date Issued

11. If laboratory services are provided enter the CLIA # assigned to the provider identified in Field 5:

12. MENTAL HEALTH / SUBSTANCE ABUSE THERAPISTS AND COUNSELORS

Nebraska Medicaid considers as a **GROUP PRACTICE** all Mental Health and Substance Abuse (MHSA) service providers that require supervision. The supervising practitioner must be identified as a group member along with the therapists/counselors providing services. (See field 15). NOTE: Psychiatrists and Clinical Psychologists may enroll as solo practice. (See field 14).

13. PHARMACY

To enroll as a pharmacy, choose the appropriate pharmacy description: (Check only one)

❑ Professional Pharmacy ❑ Nursing Facility Pharmacy ❑ Small Chain Pharmacy ❑ Other Pharmacy

❑ Independent Pharmacy ❑ Home Therapy Pharmacy ❑ Large Chain Pharmacy

14. INDIVIDUAL/SOLO PRACTICE

To enroll as an individual/solo practice or group where members bill independently, check the appropriate practice description. A provider agreement must be completed by each member and each member receives a separate Medicaid provider number.

❑ **Hospital Based Practitioner/Hospital Affiliation**
❑ **Individual or Solo Practice**
❑ **Partnership/Non-Solo Practice**
❑ **Corporation/Non-Solo Practice**
❑ **Health Maintenance Organization**
❑ **Group Practice**

15. GROUP PRACTICE

To enroll as a group practice, billing as a group and requesting payment to ONE provider number, check the appropriate practice description. One Medicaid provider number covers all practitioners identified on the agreement.

❑ Group Practice/Hospital Affilliated - utilizing the base Hospital Federal Employer ID number as the basis of the provider number.
❑ Group Practice/Partnership - made up of two or more practitioners.
❑ Group Practice/Corporation - incorporated and using a specific Federal Employer ID number.
❑ Group Practice/Health Maintenance Organization.
❑ Group Practice/Group Practice - multiple practitioner practice that may or may not be incorporated.

Provide individual member information in Field 17 on back.

16. Check if you are certified as: ❑ Independent Rural Health Clinic ❑ Hospital Based Rural Health Clinic ❑ FQHC

★★ REMINDER: ALL MEDICAL ASSISTANCE PROVIDER AGREEMENTS MUST BE SIGNED ON PAGE 2 ★★

MEDICAID USE ONLY

❑ **Approved** ❑ **Denied** **By** _____ **Date** _____

Comments:

Complete the following for each individual group member.

17. Full Name & Title	18. License Number	19. Medicare Number	20. NPI #	21. Social Security Number

If more space is needed, attach a separate list including the same information.

TERMS OF AGREEMENT

I agree to participate as a provider in the Nebraska Medical Assistance Program, and assure the Nebraska Health and Human Services System:

- That the policies and procedures of the Nebraska Health and Human Services System in the administration of the Nebraska Medical Assistance Program will be followed.
- That the payment determined in accordance with the policies of the Nebraska Health and Human Services System will be the full and complete payment for the services provided and the amount paid by the Medical Assistance program for those claims submitted by me or my authorized representative will be accepted as payment in full and that no additional payment will be claimed. If any additional payment is received, or will be received, from any other source, that amount will be deducted from the amount charged the Department; and any payment, from another source that is received after payment by the Department shall be remitted to the Department.
- That all goods and services for which payment will be claimed will be provided in compliance with the Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 (45 CFR, Parts 80, 84, and 90).
- That I will keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the Nebraska Medical Assistance Program (42 CFR 431.107).
- That the authorized representatives of the Nebraska Health and Human Services System, Federal Health and Human Services, and the Federal and State Fraud and Abuse Units will be afforded the right to review and/or receive copies of my Medical Assistance client/patient records to substantiate claims submitted by me to the Department upon receipt of a proper patient waiver. A client's/patient's signed Medical Assistance Application includes a proper patient waiver (42 CFR 431.107).
- That enrolling in NMAP does not constitute employment by the State of Nebraska.
- That all information will be disclosed to Nebraska Health and Human Services System as required by policies of NMAP.
- That any false claims (including claims submitted electronically), statements, documents or concealment of material fact may be prosecuted under applicable State or Federal laws (42 CFR 455.18).

I certify the information on this form is true, accurate and complete.

22. Sign Here _____

Signature of Provider/Authorized Representative/Agent and Title (Stamped Signature NOT Accepted) | Date | Phone Number

Distribution: Return Original Copy to Nebraska Health and Human Services, Finance and Support, Provider Enrollment, P.O. Box 95026, Lincoln, NE 68509-5026

NOTE: It is the provider's responsibility to retain a copy of the completed agreement.